ADULT (19 YEARS AND OLDER) VACCINE DOCUMENTATION/CONSENT FORM

PATIENT INFORMATION				
Date:	**Patient's First Name:** **Middle Name:**	**Last Name:**		**Maiden Name/Alias:**
Birth Date:	**Age:**	**Social Security Number:**	**Primary Language:**	**Doctor:**

Ethnicity: Hispanic ____Yes ____No

Gender ____Male ____Female

Race: (Select one or more.)
____Asian/Pacific Islander/Other ____Hawaiian
____Black or African American ____Native American/Alaska Native
____Caucasian or White ____Unknown or Other _____

Mailing Address:	**City:**	**State:**	**County:**	**Zip Code:**
Phone Number: Verizon __ Sprint __ T-Mobile __ AT&T__ Other: _____ Text Reminders: Yes _ No_		**Email Address:** @yahoo.com @hotmail.com @gmail.com @ksu.edu @cox.net Email Reminders: Yes _ No_		

INSURANCE INFORMATION

Please fill out the following information completely AND submit a copy of your insurance card.

INSURANCE

Policy Holder Name _____ Birthdate_____

Patient relationship to policy holder: Self Spouse Child Other_____

ID#_____Group #_____

IMMUNIZATION SCREENING QUESTIONNAIRE	
1. Are you sick or experiencing a high fever?	Yes No
2. Do you have allergies to medications, food, a vaccine component, or latex? List:	Yes No
3. Have you ever had a serious reaction after receiving a vaccination? Please explain:	Yes No
4. Do you have a long-term health problem with lung disease, heart disease, kidney disease, metabolic disease (e.g., diabetes), asthma, anemia, blood disorder, and/or spleen (splenectomy)?	Yes No
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	Yes No
6. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	Yes No
7. Have you had a seizure, a brain disorder, Guillain-Barré syndrome, or other nervous system problem?	Yes No
8. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	Yes No
9. Have you received vaccinations in the past 4 weeks?	Yes No
10. Are you a healthcare worker?	Yes No
11. I am a laboratory worker and may be routinely exposed to isolated or Neisseria meningitidis, or specimens potentially containing the hepatitis A or hepatitis B virus.	Yes No
12. **For women:** Are you pregnant or is there a chance you could become pregnant during the next month? If pregnant, how many weeks gestation?	Yes No
13. **For women:** Are you currently breastfeeding?	Yes No
14. I am a smoker.	Yes No
15. I am a man who has sex with men.	Yes No N/A
16. I am or will soon be living in a residence hall or a building that houses a large number of people.	Yes No
17. I am planning to travel out of the U.S.? Location(s):	Yes No
18. I have received a tetanus and diphtheria injection in the last 10 years and it contained pertussis, whooping cough.	*Yes Unknown No N/A*
*19. **For those 26 years of age and younger:** I received the Human Papillomavirus (HPV, Gardasil) vaccine series as a child.*	*Yes Unknown No N/A*
*20. **For those born in 1980 or after:** I have had chickenpox or have completed the 2 dose series.*	*Yes Unknown No N/A*
*21. **For those born in 1957 or after:** I have completed the 2 doses series of MMR.*	*Yes Unknown No N/A*
*22. **For those 60 years of age and older:** I have received the Shingles (Zoster) vaccine.*	*Yes Unknown No N/A*
*23. **For those 65 years of age and older:** I have received the Pneumococcal vaccines, both PPSV23 and Prevnar 13.*	*Yes Unknown No N/A*
24. Did you bring your immunization record with you?	*Yes No*

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I have been offered a copy of the Vaccine Information Statement(s) (VIS) checked below. I have read, had explained to me, and understand the information in the VIS(s). I ask that the vaccine(s) checked below be given to me or to the person named below for whom I am authorized to make this request. I consent to inclusion of this immunization data in the Kansas Immunization Registry for myself or on behalf of the person named below.

☐ Tdap ☐ Td ☐ Hep A ☐ Hep B ☐ Twinrix ☐ Gardasil (4,9) ☐ Meningococcal (A,C,Y,W-135)

☐ MMR ☐ Varicella ☐ Zostavax ☐ Hib ☐ Polio/IPV ☐ Influenza ☐ Meningococcal B

☐ Prevnar 13 ☐ PPSV23 ☐ Yellow Fever ☐ Typhoid ☐ Japanese Encephalitis ☐ _____ ☐ Pre-Exposure Rabies

_____ _____

Signature of Patient or Parent/Guardian Date

FOR CLINICAL USE ONLY

VACCINE	DOSE	EXT	SITE	ROUTE	VIS DATE	MANUFACTURER LOT #	EXP DATE
Td Tdap	0.5 mL 1 2 3 4 5 6	RT LT	Deltoid	IM	Td 02/24/15 Tdap 02/24/15		
Hepatitis A	1.0mL 1 2	RT LT	Deltoid	IM	HepA 07/20/2016		
Hepatitis B	1.0 mL 1 2 3	RT LT	Deltoid	IM	HepB 07/20/2016		
Twinrix (HepA & HepB)	1.0 mL 1 2 3	RT LT	Deltoid	IM	HepA 07/20/16 HepB 07/20/16		
HPV (Gardasil 4,9)	0.5 mL 1 2 3	RT LT	Deltoid	IM	Gardasil4 05/17/13 Gardasil9 03/31/16		
MCV4 or MPSV4 (Menveo/Menactra or Menomune)	0.5 mL 1 2	RT LT	Deltoid	IM	Meningococcal 03/31/16		
MMR	0.5 mL 1 2	RT LT	Upper Arm	SC	MMR 04/20/12		
Varicella	0.5 mL 1 2	RT LT	Upper Arm Thigh	SC	Chickenpox 03/13/08		
Zostavax	0.5mL 1	RT LT	Upper Arm Thigh	SC	Shingles 10/06/09		
Hib	0.5 mL 1 2 3 4 5	RT LT	Deltoid	IM	Hib 04/02/15		
Polio/IPV	0.5 mL 1 2 3 4 5	RT LT	Upper Arm Thigh	IM SC	IPV 07/20/16		
Influenza IIV3 IIV4	0.50mL 1 2	RT LT	Deltoid	IM	Inactivated 08/07/2015		
Meningococcal B	0.5 mL	RT LT	Deltoid	IM	MenB 08/09/16		
PCV13 (Prevnar 13)	0.5 mL 1 2 3 4	RT LT	Deltoid	IM	Pneumococcal Conjugate 11/05/15		
PPV23	0.5 mL 1 2	RT LT	Deltoid	IM	Pneumococcal Polysaccharide 04/24/15		
Yellow Fever (9 months – 59 years)	0.5 mL 1 2	RT LT	Upper Arm	SC	Yellow Fever 03/30/11		
Typhim Vi (≥2 years) Vivotif (≥7 years)	0.5 mL 1 2	RT LT	Deltoid	IM PO (oral)	Typhoid 05/29/12		
Japanese Encephalitis (2 months and older)	0.5 mL 1 2	RT LT	Deltoid	IM	Japanese Encephalitis 01/24/14		
Pre-Exposure Rabies	0.5 mL 1 2 3	RT LT	Deltoid	IM	Pre-Exposure Rabies 10/06/09		
Other							

_____ _____

Signature and Title of Vaccine Administrator Date